



Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE# 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>42,090</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>42,090</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,511</u>	<u>2,205</u>	<u>1,856</u>	<u>8,572</u>	8
9	SNF/PED					9
10	ICF	<u>17,088</u>	<u>6,637</u>	<u>17</u>	<u>23,742</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,599</u>	<u>8,842</u>	<u>1,873</u>	<u>32,314</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 76.77%D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started 02/01/93J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 02/01/93 NO ☐K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 29 and days of care provided 1,856Medicare Intermediary AdminaStar

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK R # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
<b>1</b>	<b>A. General Services</b>											
1	Dietary	170,807	25,346	5,870	202,023		202,023		202,023			1
2	Food Purchase		127,495		127,495	(3,279)	124,216	(2,974)	121,242			2
3	Housekeeping	75,420	8,474		83,894		83,894		83,894			3
4	Laundry	78,914	12,913		91,827		91,827		91,827			4
5	Heat and Other Utilities			68,174	68,174		68,174	(60)	68,114			5
6	Maintenance	77,072	21,460	11,313	109,845		109,845		109,845			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	402,213	195,688	85,357	683,258	(3,279)	679,979	(3,034)	676,945			8
<b>9</b>	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	999,885	57,011	11,400	1,068,296		1,068,296	(280)	1,068,016			10
10a	Therapy	37,024	1,049		38,073		38,073		38,073			10a
11	Activities	77,305	7,992	1,259	86,556		86,556		86,556			11
12	Social Services	57,940	258	1,670	59,868		59,868		59,868			12
13	Nurse Aide Training			1,721	1,721		1,721		1,721			13
14	Program Transportation			8,103	8,103		8,103		8,103			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,172,154	66,310	27,753	1,266,217		1,266,217	(280)	1,265,937			16
<b>17</b>	<b>C. General Administration</b>											
17	Administrative	186,019			186,019		186,019		186,019			17
18	Directors Fees											18
19	Professional Services			68,298	68,298		68,298	(15,576)	52,722			19
20	Dues, Fees, Subscriptions & Promotions			31,799	31,799		31,799	(10,339)	21,460			20
21	Clerical & General Office Expenses	81,305	18,807	65,579	165,691		165,691	(43,021)	122,670			21
22	Employee Benefits & Payroll Taxes			315,276	315,276	3,279	318,555	(2,161)	316,394			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,385	4,385		4,385		4,385			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			59,050	59,050		59,050		59,050			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	267,324	18,807	544,387	830,518	3,279	833,797	(71,097)	762,700			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,841,691	280,805	657,497	2,779,993		2,779,993	(74,411)	2,705,582			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE  
0038653  
COST REPORT RECLASSIFICATIONS  
01/01/00  
12/31/00

SCHEDULE V  
LINE #

22	EMPLOYEE BENEFITS	3,279
2	FOOD	3,279

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	
19	PROFESSIONAL FEES	

To reclass cost of appealing real estate taxes

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			15,578	15,578		15,578	302	15,880			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,678	37,678		37,678	(12,249)	25,429			32
33	Real Estate Taxes			62,340	62,340		62,340	(734)	61,606			33
34	Rent-Facility & Grounds			445,550	445,550		445,550		445,550			34
35	Rent-Equipment & Vehicles			15,866	15,866		15,866	(6,046)	9,820			35
36	Other (specify):*			3,756	3,756		3,756		3,756			36
37	<b>TOTAL Ownership</b>			580,768	580,768		580,768	(18,727)	562,041			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	52,956	63,656	32,107	148,719		148,719		148,719			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		7,896		7,896		7,896	(7,896)				41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	52,956	71,552	95,243	219,751		219,751	(7,896)	211,855			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,894,647	352,357	1,333,508	3,580,512		3,580,512	(101,034)	3,479,478			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653**Report Period Beginning: **01/01/00**Ending: **12/31/00****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>OHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,625)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	302	30		9
10	Interest and Other Investment Income	(12,249)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(349)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,579)	21		18
19	Entertainment	(2,161)	22		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,437)	21		24
25	Fund Raising, Advertising and Promotional	(3,395)	20		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax	(7,754)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,944)	20		28
29	Other-Attach Schedule	(30,843)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (101,034)		\$	30

<b>OHF USE ONLY</b>							
48		49		50		51	
						52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (101,034)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

STATE OF ILLINOIS  
WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE

Page 5A

ID# 0038653  
Report Period Beginning: 01/01/00  
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Deferred Maintenance	\$	6 1
2			2
3	VENDING SUPPLIES	(7,896)	41 3
4	COPY REVENUE	(20)	21 4
5	CABLE REVENUE	(60)	5 5
6	REAL ESTATE TAX FOR NON CARE PROP	(734)	33 6
7	NURSES UNIFORMS	(280)	10 7
8	PRIOR YEAR UNALLOWABLE LEGAL FEES	(12,179)	19 8
9	COLLECTION SERVICE	(3,397)	19 9
10	CAPITALIZED EQUIPMENT	(6,046)	35 10
11	MISC. INCOME	(231)	21 11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
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32			32
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34			34
35			35
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37			37
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39			39
40			40
41			41
42			42
43			43
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67			67
68			68
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70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(30,843)	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(2,974)											(2,974)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(60)											(60)	5
6	Maintenance													6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(3,034)</b>											<b>(3,034)</b>	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(280)											(280)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(280)</b>											<b>(280)</b>	16
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(15,576)											(15,576)	19
20	Fees, Subscriptions & Promotions	(10,339)											(10,339)	20
21	Clerical & General Office Expenses	(43,021)											(43,021)	21
22	Employee Benefits & Payroll Taxes	(2,161)											(2,161)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(71,097)</b>											<b>(71,097)</b>	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(74,411)</b>											<b>(74,411)</b>	29



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE** # **0038653** Report Period Beginning: **01/01/00** Ending: **12/31/00**

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	302											302	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,249)											(12,249)	32
33	Real Estate Taxes	(734)											(734)	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles	(6,046)											(6,046)	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	(18,727)											(18,727)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(7,896)											(7,896)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>	(7,896)											(7,896)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(101,034)											(101,034)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT NATAUPSKY	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
15	V							\$		15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total		\$					\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
15	V								\$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total		\$					\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
15	V		\$					\$		15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total		\$					\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item		Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
15	V			\$				\$		15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total			\$				\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V		\$			\$		\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$	0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT NATAUPSKY	ADMINISTRATOR	ADMIN.	100.00	NONE	40	100.00	SALARY	\$ 128,736	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 128,736		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_\_) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25



Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK F**# **0038653**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	1st SUBURBAN BANK		X	WORKING CAPITAL	INTEREST	8/1/99	410,722	410,722	8/1/01	8.5000	37,678	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 410,722	\$ 410,722			\$ 37,678	9	
	B. Non-Facility Related*												
10	Supplemental Schedule											10	
11	INTEREST INCOME		X								(12,249)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (12,249)	14	
15	TOTALS (line 9+line14)						\$ 410,722	\$ 410,722			\$ 25,429	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number WRHC & RC, INC. D/B/A WOODSTOCK RES # 0038653 Report Period Beginning: 01/01/00 Ending: 12/31/00

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$



Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>60,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>61,606</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>1,606</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>60,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>61,606</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>51,377</b>	8
	1996	<b>57,524</b>	9
	1997	<b>58,875</b>	10
	1998	<b>60,380</b>	11
	1999	<b>61,606</b>	12

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**2000 REAL ESTATE TAX ACCRUAL= 61,606 REDUCED TO 60,000**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

Facility Name &amp; ID Number WRHC &amp; RC, INC. D/B/A WOODSTOCK RESIDENCE

# 0038653

Report Period Beginning:

01/01/00

Ending:

12/31/00

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 29,252 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 1

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9		<b>PARKING LOT PAVEMENT</b>	1994		6,149	615	10	615		3,898
10		<b>FLOOR TILE</b>	1995		9,053	905	10	905		4,978
11		<b>ROOF IMPROVEMENTS</b>	1996		9,800	980	10	980		4,492
12		<b>FRONT DOOR</b>	1998		6,435	644	10	644		1,717
13		<b>PAINTING</b>	2000		16,508	70	20	70		70
14		<b>ROOF IMPROVEMENTS</b>	2000		186,754	795	20	795		795
15		<b>ROOF IMPROVEMENTS</b>	2000		2,107	61	20	61		61
16		<b>ROOF IMPROVEMENTS</b>	2000		316	8	20	8		8
17		<b>ROOF IMPROVEMENTS</b>	2000		900	15	20	15		15
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 238,022	\$ 4,093		\$ 4,093	\$	16,034

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
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23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
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24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
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29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
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27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
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16										16
17										17
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27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9										9
10										10
11										11
12										12
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14										14
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16										16
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27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
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28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9										9
10										10
11										11
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27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
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27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
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28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.  
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
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27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
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26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	<b>TOTAL (lines 4 thru 35)</b>				\$	\$		\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESI # 0038653**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 159,134	\$ 11,006	\$ 11,006			\$ 85,592	37
38	Current Year Purchases	12,940	479	781	302		781	38
39	Fully Depreciated Assets							39
40								40
41	<b>TOTALS</b>	\$ 172,074	\$ 11,485	\$ 11,787	\$ 302		\$ 86,373	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	<b>FACILITY</b>	<b>93 DODGE VAN</b>	<b>1996</b>	\$ 7,259				3	\$ 7,259	42
43										43
44										44
45										45
46	<b>TOTALS</b>			\$ 7,259					\$ 7,259	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 417,355	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 15,578	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 15,880	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 302	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 109,666	51

\*\*

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	<b>TOTALS</b>	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.



WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE  
0038653  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
WODSTOCK RESIDENCE	159,134	11,006	11,006		85,592
TOTALS	159,134	11,006	11,006		85,592

LINE 29: CURRENT YEAR

WODSTOCK RESIDENCE	12,940	479	781	302	781
TOTALS	12,940	479	781	302	781

LINE 30: FULLY DEPRECIATED

WODSTOCK RESIDENCE					
TOTALS					

TOTALS (Should Tie to Totals on Page 13)

WODSTOCK RESIDENCE	172,074	11,485	11,787	302	86,373
TOTALS	172,074	11,485	11,787	302	86,373

## XII. RENTAL COSTS

**A. Building and Fixed Equipment (See instructions.)**

**1. Name of Party Holding Lease:** **AGE PARTNERSHIP**

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions		115	02/01/93	445,550			4
5								5
6								6
7	TOTAL		115		\$ 445,550			7

**8. List separately any amortization of lease expense included on page 4, line 34.**

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☒ YES ☐ NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment.** (See instructions.)

**15. Is Movable equipment rental included in building rental?**

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 9,200

**Description:** SEE ATTACHED SCHEDULE

**(Attach a schedule detailing the breakdown of movable equipment)**

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$		21

**10. Effective dates of current rental agreement:**

Beginning 02/01/93

**Ending** **01/13/15**

**11. Rent to be paid in future years under the current rental agreement:**

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. /2001 \$ 446,652

13.                      /2002      \$ 452,100

14.	<u>2003</u>	\$ <u>457,570</u>
-----	-------------	-------------------

**\* If there is an option to buy the building, please provide complete details on attached schedule.**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE** # **0038653** Report Period Beginning: **01/01/00** Ending: **12/31/00**  
**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input checked="" type="checkbox"/>  HOURS PER AIDE <u>32</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input checked="" type="checkbox"/>  HOURS PER AIDE <u>108</u>
---	--	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,488	\$	\$ 1,488
2	Books and Supplies		233		233
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,721	\$	\$ 1,721
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,721			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
							1	Licensed Occupational Therapist	39-1/39-3	
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,015			4,015	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1/39-3	hrs	33,018		22,715			55,733	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				48,406		48,406	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**	39-2					15,250		15,250	13
14	TOTAL			\$ 52,956		\$ 32,107	\$ 63,656		\$ 148,719	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

### SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

Special Services - Supplies (Column 6 - Other)	Amount
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	4,152
4 Equipment Rental	
5 LAB	1,246
6 X RAY	9,852
7	
8	
9	
10	
	15,250

Outside Therapies (Column 5 - Other)	Amount
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	

## STATE OF ILLINOIS

Page 17

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE** # **0038653** Report Period Beginning: **01/01/00** Ending: **12/31/00**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/00** (last day of reporting year)

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 76,903	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance )	542,972		3
4 Supply Inventory (priced at )	7,330		4
5 Short-Term Investments			5
6 Prepaid Insurance	17,758		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <a href="#">See supplemental schedule</a>	25,598		9
<b>TOTAL Current Assets</b>			
10 (sum of lines 1 thru 9)	\$ 670,561	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cos	238,022		15
16 Equipment, at Historical Cost	173,288		16
17 Accumulated Depreciation (book methods)	(140,203)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):	45,384		22
23 Other(specify): <a href="#">See supplemental schedule</a>			23
<b>TOTAL Long-Term Assets</b>			
24 (sum of lines 11 thru 23)	\$ 316,491	\$	24
<b>TOTAL ASSETS</b>			
25 (sum of lines 10 and 24)	\$ 987,052	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 393,280	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	410,722		29
30 Accrued Salaries Payable	53,752		30
31 Accrued Taxes Payable (excluding real estate taxes)	34,787		31
32 Accrued Real Estate Taxes(Sch.IX-B)	60,000		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <a href="#">See supplemental schedule</a>	89,121		36
37			37
<b>TOTAL Current Liabilities</b>			
38 (sum of lines 26 thru 37)	\$ 1,041,662	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 <a href="#">See supplemental schedule</a>	294,571		43
44			44
<b>TOTAL Long-Term Liabilities</b>			
45 (sum of lines 39 thru 44)	\$ 294,571	\$	45
<b>TOTAL LIABILITIES</b>			
46 (sum of lines 38 and 45)	\$ 1,336,233	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$ (349,181)	\$	47
<b>TOTAL LIABILITIES AND EQUITY</b>			
48 (sum of lines 46 and 47)	\$ 987,052	\$	48

\*(See instructions.)

## STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name &amp; ID Number WRHC &amp; RC, INC. D/B/A WOODSTOCK RESIDENCE # 0038653

Report Period Beginning: 01/01/00

Ending:

12/31/00

## SUPPLEMENTAL SCHEDULE OF OTHER ASSETS &amp; LIABILITIES

As of 12/31/00

## OTHER CURRENT ASSETS:

Real Estate Tax Escrow

DEPOSITS

EARNED INCOME CREDIT

ACCRUED IL REPLACEMENT TAX

Amount

Amount

23,305

1,963

330

25,598

## OTHER NON CURRENT ASSETS:

Construction In Progress

Utility Deposit

Loan Costs

## OTHER CURRENT LIABILITIES:

Accrued Expenses

Accrued R. E. Tax -

Non Care Property

DUE TO SHAREHOLDER

EXCHANGE

Amount

Amount

87,525

1,596

89,121

## OTHER NON CURRENT LIABILITIES:

DEFERRED RENT

294,571

294,571

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (423,923)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">Schedule attached</a>	<b>1</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (423,922)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>74,741</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 74,741</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (349,181)</b>	<b>24</b> *

\* This must agree with page 17, line 47.



Facility Name & ID Number	WRHC & RC, INC. D/B/A WOODSTC #	0038653	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	(423,922)
----------------------------	-----------

Adjustments:

-

-

-

rounding	(1)
----------	-----

Total adjustments	(1)
-------------------	-----

Balance - Beginning of Year	(423,923)
-----------------------------	-----------

Equity(Deficit) from Page 17 Col 1	(349,181)
------------------------------------	-----------

Related Party

Equity(Deficit)	0
-----------------	---

Income	0
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-

Combined Equity - End of Year	(349,181)
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Facility Name &amp; ID Number WRHC &amp; RC, INC. D/B/A WOODSTOCK RESID # 0038653 Report Period Beginning: 01/01/00

Ending: 12/31/00

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,669,577	1
2	Discounts and Allowances for all Levels	(382,054)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,287,523	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	201,779	6
7	Oxygen	10,698	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 212,477	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	559	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,625	14
15	Telephone, Television and Radic	60	15
16	Rental of Facility Space		16
17	Sale of Drugs	69,855	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	61,583	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 134,682	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	11,803	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,803	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See supplemental schedule	8,768	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,768	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,655,253	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	683,258	31
32	Health Care	1,266,217	32
33	General Administration	830,518	33
	<b>B. Capital Expense</b>		
34	Ownership	580,768	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	156,615	35
36	Provider Participation Fee	63,136	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,580,512	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	74,741	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 74,741	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not completed If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissions	
2 COPIES ADJ OUT P. 5	20
3 UNIFORMS ADJUSTED OUT P.5	280
4 VENDING REVENUE (COST ADJUSTED OUT ON P.5)	8,468
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	8,768

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESIDENCE**# **0038653**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,061	1,155	\$ 30,151	\$ 26.10	1
2	Assistant Director of Nursing	1,466	1,596	36,115	22.63	2
3	Registered Nurses	7,417	7,975	136,806	17.15	3
4	Licensed Practical Nurses	17,616	18,942	302,817	15.99	4
5	Nurse Aides & Orderlies	55,119	59,912	493,996	8.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,229	1,333	52,956	39.73	7
8	Rehab/Therapy Aides	4,298	4,768	37,024	7.77	8
9	Activity Director	1,708	1,780	30,554	17.17	9
10	Activity Assistants	6,202	6,469	46,751	7.23	10
11	Social Service Workers	3,727	3,919	57,940	14.78	11
12	Dietician					12
13	Food Service Supervisor	1,620	1,740	25,303	14.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,370	19,132	145,503	7.61	15
16	Dishwashers					16
17	Maintenance Workers	6,903	7,463	77,072	10.33	17
18	Housekeepers	9,373	9,751	75,420	7.73	18
19	Laundry	10,764	11,216	78,914	7.04	19
20	Administrator	1,929	1,938	128,736	66.43	20
21	Assistant Administrator	2,078	2,078	57,282	27.57	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,022	6,022	81,304	13.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	156,902	167,189	\$ 1,894,644 *	\$ 11.33	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	36	\$ 5,870	1-3	35
36	Medical Director	MONTHLY	3,600	9-3	36
37	Medical Records Consultant	MONTHLY	2,352	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	2,760	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,259	11-3	44
45	Social Service Consultant	33	1,670	12-3	45
46	Other(specify) <u>Qa/Ur Cmtee Fee</u>	24	2,400	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	118	\$ 19,911		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	96	3,888	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	96	\$ 3,888		53

**SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS**

## B. CONSULTANT SERVICES

<u># of Hrs. Actually Worked</u>	<u># of Hrs. Paid and Accrued</u>	<u>Reporting Period Total Salaries, Wages</u>	<u>Average Hourly Wage</u>
		\$	\$
<u>0</u>	<u>0</u>	<u>\$ 0</u>	<u>#DIV/0!</u>

Facility Name & ID Number **WRHC & RC, INC. D/B/A WOODSTOCK RESII**

**XIX. SUPPORT SCHEDULES**

STATE OF ILLINOIS

# **0038653**

Report Period Beginning: **01/01/00**

Page 21

Ending: **12/31/00**

<b>A. Administrative Salaries</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 20%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr> <td>ROBERT NATAUPSKY</td> <td>ADMINISTRATOR</td> <td>100%</td> <td>\$ 128,736</td> </tr> <tr> <td>GAIL HELLYBUCK</td> <td>ASST. ADMIN</td> <td></td> <td>57,282</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 186,018</td> </tr> </tbody> </table>				Name	Function	Ownership %	Amount	ROBERT NATAUPSKY	ADMINISTRATOR	100%	\$ 128,736	GAIL HELLYBUCK	ASST. ADMIN		57,282																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 186,018	<b>D. Employee Benefits and Payroll Taxes</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr><td>Workers' Compensation Insurance</td><td>\$ 32,674</td></tr> <tr><td>Unemployment Compensation Insurance</td><td>27,832</td></tr> <tr><td>FICA Taxes</td><td>140,590</td></tr> <tr><td>Employee Health Insurance</td><td>110,552</td></tr> <tr><td>Employee Meals</td><td>3,279</td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td></td></tr> <tr><td>EMPLOYEE APPRECIATION</td><td>1,467</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 316,394</td> </tr> </tbody> </table>				Description	Amount	Workers' Compensation Insurance	\$ 32,674	Unemployment Compensation Insurance	27,832	FICA Taxes	140,590	Employee Health Insurance	110,552	Employee Meals	3,279	Illinois Municipal Retirement Fund (IMRF)*		EMPLOYEE APPRECIATION	1,467															TOTAL (agree to Schedule V, line 22, col.8)	\$ 316,394	<b>F. Dues, Fees, Subscriptions and Promotions</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 40%;">Amount</th> </tr> </thead> <tbody> <tr><td>IDPH License Fee</td><td>\$ 200</td></tr> <tr><td>Advertising: Employee Recruitment</td><td>18,717</td></tr> <tr><td>Health Care Worker Background Check (Indicate # of checks performed 85 )</td><td>1,020</td></tr> <tr><td>YELLOW PAGES</td><td>6,944</td></tr> <tr><td>LICENSES</td><td>813</td></tr> <tr><td>DUES AND SUBSCRIPTIONS</td><td>710</td></tr> <tr><td>COMMUNITY RELATIONS</td><td>100</td></tr> <tr><td>PROMOTION</td><td>3,295</td></tr> <tr><td> </td><td> </td></tr> <tr><td>Less: Public Relations Expense</td><td>(100)</td></tr> <tr><td>Non-allowable advertising</td><td>(3,295)</td></tr> <tr><td>Yellow page advertising</td><td>(6,944)</td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 21,460</td> </tr> </tbody> </table>				Description	Amount	IDPH License Fee	\$ 200	Advertising: Employee Recruitment	18,717	Health Care Worker Background Check (Indicate # of checks performed 85 )	1,020	YELLOW PAGES	6,944	LICENSES	813	DUES AND SUBSCRIPTIONS	710	COMMUNITY RELATIONS	100	PROMOTION	3,295			Less: Public Relations Expense	(100)	Non-allowable advertising	(3,295)	Yellow page advertising	(6,944)			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 21,460
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\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? VARIOUS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,260 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 63,135  
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 3,279 Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,625
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%:L14  
d. Have vehicle usage logs been maintained? YES  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.